FLEXIBLE BENEFITS PROGRAM 2006

Important Contact Information

Vendor	Phone	Website
Community First Health Plan	210-358-6020	www.cfhp.com
City of San Antonio Employee Benefits	210-207-8705	http://COSAWEB/benefits
Aetna Life Insurance	1-800-523-5065	www.aetna.com
Spectera	1-800-638-3120	www.spectera.com
Delta Dental Plan	1-800-422-4234	www.deltadentalins.com
CitiDent	1-800-336-8264	www.deltadentalins.com
ICMA Retirement Corporation	1-800-735-7202	www.icmarc.com
San Antonio City Employees Federal Credit Union	210-554-3545	www.safefcu.com
National Bond and Trust	1-800-303-6244	www.nbtco.com
Nationwide Retirement Solution	1-877-677-3678	www.nrsforu.com
Texas Municipal Retirement System (TMRS)	1-800-924-8677	www.tmrs.com
WHP Health Initiatives	1-800-207-2568	www.walgreens.com
Deer Oaks EAP	210-615-8880	www.deeroaks.com
Tricare Medical Supplement Association & Society Insurance Corp. (ASI)	1-800-638-2610	www.corporatetricaresupp.com

CONTENTS

Introduction	How to Use This Book.....	4
Eligibility	Employment Requirements.....	5
	Leave of Absence.....	5
	Dependents.....	5
	Changes in Family Status.....	6
Medical Plan Benefits	Summary of Medical Plan Options…….	7
Prescription Drug Benefits	Network, Premiums, and Copays…….	8
Dental Plans	Summary of Dental Plan Options (CitiDent, DHMO).	11
Flexible Spending Accounts (FSA)	Summary of Benefits…….	13
Life Coverage Benefits	Basic, AD&D, Supplemental….. Policy Conversion, Excess Coverage Tax Table	17
Vision Benefits	Spectera Managed Vision Plan…….	19
Extended Sick Leave	Short Term, Long Term Disability……..	20
Retirement Benefits	TMRS, Deferred Compensation (457 Plans)……..	21
Summary of Medical Plan	Summary of Medical Plans & Rates ……..	22
Enrollment Procedure	Completing the Enrollment Form.....	26
Benefits Worksheet	Cost Calculation Matrix…….	29
Flexible Spending Account Worksheet	FSA Expense Calculator……..	30

INTRODUCTION

Under the City of San Antonio Benefits Program, if you are a full-time, non-uniformed, active employee, you are eligible to participate in excellent benefit plans which help pay for your health and dependent care needs. **Benefits options presently offered include**:

- Medical (1 PPO, 1 HMO, or 1 TRICARE Medical Supplement Plan)
- Dental (1 DPO or 1 DHMO)
- Vision (Spectera)
- Additional Life Insurance (in addition to Basic Coverage)
- Long Term Disability (in addition to what the City provides)
- FSA Reimbursement Accounts (Health Care and Dependent Day Care Reimbursement)

Medical Plan Coverage may be waived:

Full-time City of San Antonio Employees may elect to waive medical coverage under the City's Flexible Benefits Program. If you choose to enroll in the City's medical plan, the medical coverage provided by the City of San Antonio is considered primary for you as a City employee, and pays your medical expenses before any other group medical coverage. The other plan benefits listed above are also optional.

Default Plan Elections

Any new employee who does not enroll or waive medical coverage on or before the 31st day of employment will automatically be enrolled in the CitiMed PPO plan. Any current employee who does not waive medical coverage or change plans during the open enrollment period will automatically be re-enrolled in their current medical plan. If you have any questions, please do not hesitate to contact the Employee Benefits Office at 210-207-8705, or your Departmental Human Resource Specialist (HRS).

ELIGIBILITY

Employment Requirements

Who is eligible to participate in the City's Benefit Program?

- Full-time Civilian employees of the City of San Antonio
- Fire and Police uniformed employees who opt out of the Uniformed Plan
- Eligible dependents

Part-time and temporary employees (including seasonal employees) are NOT eligible to enroll in the benefits program.

Leave of Absence

If you are on a paid or non-paid leave of absence due to disability, workers' compensation, etc., you may still continue your health coverage as a full-time employee. If you do not receive a paycheck and automatic benefit deductions are not taken, you will be required to contact the Employee Benefits Office to arrange to pay for premiums during the time you are on a leave of absence. Failure to do so will result in suspension of benefits for the duration of your leave of absence.

Dependents

Who are eligible dependents?

Your dependents are eligible for medical, dental and vision coverage based on your status as a full-time employee and the coverage level you choose (employee plus child(ren) or employee plus spouse or employee plus family).

Eligible dependents include:

- Your legal spouse, (including a common-law spouse with an informal marriage certificate)
- Your unmarried child(ren), including stepchild(ren), legally adopted child(ren), and child(ren) for whom you have obtained court-ordered legal guardianship, as long as they are **19** years of age and under (see plan document for detailed information), or up to **23** years of age if they are full-time students and are dependent on you for their support (***proof of student status required)***
- Your disabled child(ren) at any age if their disability began before age 20 and while they were covered under the City's benefit program

ELIGIBILITY (cont'd)

Dependents do not include:

- Your common-law spouse without a declaration of informal marriage which has been recorded as provided by law
- Your parent or your spouse's parent
- Your grandchild(ren) or your spouse's grandchild(ren), unless they meet the definition of court ordered legal guardianship
- A spouse or child who is employed by the City and is covered by any City Medical Plan
- Any dependents who are already covered by another City Medical Plan

Changes in Family Status

If there is a legal change in family status, the employee may add or drop dependent coverage. A legal change in family status would allow the employee to change the coverage level of the medical, dental, and vision plans, and allow changes to their Health Care and/or Dependent Care Reimbursement accounts. Employees have 31 calendar days to notify the Employee Benefits Office to make the change. **If not done within 31 days of the legal change of status, the change cannot be made until the next re-enrollment period.** Legal documentation is required with any change request and the request must be made in person in the Employee Benefits Office. A legal change in family status includes: divorce; marriage; death, birth or adoption of a child; change in employment status of the employee's spouse; or ineligibility of a child due to age or change in student status. Once an employee or dependent becomes ineligible for coverage, they will no longer receive benefits from the date of ineligibility.

Once an employee has enrolled in the benefit plans of their choice, no changes can be made during the year until the next annual re-enrollment.

MEDICAL PLAN BENEFIT OPTIONS

Option 1 - CitiMed PPO*

In-Network Benefits-

This comprehensive medical plan option offers employees access to a Preferred Provider Organization (PPO) or Providers Network whose services are discounted, saving the Employee and City money. Participants who choose network providers pay an annual deductible of $500 ($1,000 for family coverage) which begins January 1 and accumulates through December 31 of each plan year. In-network PPO coverage includes the added benefit of a $15 Office Visit Co-payment which is not subject to deductible or co-insurance. Once a participant's deductible is satisfied the member cost drops to 20% of discounted eligible expenses to a maximum of $2,000 per individual or $4,000 for family coverage, excluding the deductible. Amounts above this annual maximum are paid at 100% of eligible expense.

Out-of-Network Benefits-

Services rendered by Out-of-Network providers are subject to a separate $1,000 individual ($2,000 for family coverage) annual deductible which begins January 1 and accumulates through December 31 of each plan year. Once a participant's annual out-of-network deductible is satisfied the patient liability drops to 40% of eligible billed charges to a maximum of $4,000 per individual or $8,000 for family coverage, excluding the deductible. Out-of-Network penalties for emergency and urgent care services can be waived provided the employee contacts the CitiMed Pre-cert information line located on the back of your Medical ID card within 48 hours of episode.

Pre-certification-

CitiMed Plan participants are required to pre-certify hospital admissions and outpatient surgery. Employees who are ordered by their physicians to enter the hospital for medical services must obtain *prior-authorization* through the City's Utilization Review Program. Please refer to the back of your CitiMed Identification card for contact information. **Failure to obtain pre-certification will result in reduction in benefits.**

*** For all employees who enroll in the CitiMed PPO Plan on or before January 1, 2006, COSA will contribute $250 to a Healthcare FSA Reimbursement Account for you and your family to use during the 2006 plan year. Information about the FSA Account begins on page 13.**

BI-WEEKLY CITIMED PPO PREMIUM

Employee Only	EE+Child(ren)	EE+Spouse	EE+Family
$3.50	$12.50	$21.00	$29.50

Option 2 - CitiMed HMO

The CitiMed HMO plan offers employees the advantage of no deductibles, no claim forms. Enrollees in the CitiMed HMO are required to select a Primary Care Physician (PCP) to access medical care or obtain referral to medical specialists. For instance, HMO participants must consult with their HMO care provider before seeking specialized medical services. A copayment will be collected by the provider at the time of service. Contact Community First Health Plans for additional information on selecting or changing Primary Care Providers. Contact information is located on the back of your CitiMed HMO medical card or online at www.cfhp.com. In addition to a flat $15 copay per office visit, participants pay $0 per hospital confinement, $100 per emergency room visit (waived if admitted), and $15 copay for a comprehensive eye exam (EyeMasters Vision Care Centers only).

BI-WEEKLY CITIMED HMO PREMIUM

Employee Only	EE+Child(ren)	EE+Spouse	EE+Family
$24.00	$50.00	$61.50	$85.00

PRESCRIPTION DRUG BENEFITS – Included with Either PPO or HMO Choice

Enrollment in the Walgreen's WHI prescription drug program is a feature of all CitiMed PPO and HMO medical plans. The CitiMed Rx program is a carved out medical benefit in which employees pay co-payments directly to network pharmacy providers based on the type of drug prescribed. The Walgreen's WHI retail pharmacy network includes all Walgreen's, HEB, Wal-Mart, Sam's Club, and Target pharmacies.

Here is how the program works. Each CitiMed Medical card bears the Walgreen's WHI logo which should be presented at the pharmacy each time you fill a prescription. Along with the logo each CitiMed medical card has a unique Rx ID number which allows the pharmacy to assess benefits and charge correct copayments. Brand name drugs listed on the CitiMed Preferred Drug List (Formulary List) will be dispensed at a lower co-payment than Non-formulary Brand medications. A complete list of CitiMed formulary drugs can be found on the COSAWEB under "Summary of Benefits- Rx Formulary). Ninety (90) Day Supply or Maintenance medications are available to participants only at Walgreen's retail pharmacies and through the mail-order program. Contact the Employee Benefits Office to obtain a registration form to set up a Walgreen's mail-order account or visit us on-line at Cosaweb/benefits. See the table below for specific in-network co-payments effective January 1, 2006.

30 Day Supply- Retail	**CitiMed PPO**	**CitiMed HMO**
Generic……	$7	$10
Brand (Preferred List)…….....	$20	$20
Brand (Non-formulary)……..	$40	$40
90 Day Supply (Maintenance) - Retail		
Generic……..……	$21	$20
Brand (Preferred List)……	$60	$40
Brand (Non-formulary)……..	$120	$80
90 Day Supply (Maintenance) - Mail Order		
Generic……	$0	$0
Brand (Preferred List)……	$30	$30
Brand (Non-formulary)……...	$30	$30

Retail Pharmacy Network: Walgreen's, HEB, Wal-Mart, Sam's Club, Target Pharmacies only. Other independent participating pharmacies can be found at http://COSAWEB/benefits or calling Employee Benefits at (210) 207-8705.

Premiums included in Medical Premium Rate

MEDICAL PLAN BENEFIT OPTIONS (cont'd)

CITIMED PPO ANNUAL ROUTINE PHYSICAL BENEFITS

Eligible employee and dependents:

100% coverage on in-network routine preventive health benefits for employee and eligible dependents over age 2. This benefit includes an annual physical (well child exam for covered dependents) and age appropriate tests ordered by treating physician. Maximum coverage limit is $300 annually per person.

Additional Gender/Age Specific Covered Benefits:

Immunizations 100% covered with no deductible for physician recommended immunizations.

Mammogram: 100% coverage with no deductible for one routine mammogram per calendar year for female covered persons age 35 and over;

Pap Smear: 100% coverage with no deductible for one annual pelvic exam (doctor's procedure charge, lab expenses and office visit) per calendar year for female covered persons.

Prostate Specific Assay (PSA): 100% coverage with no deductible for a physical examination for the detection of prostate cancer and prostate -specific antigen test used for the detection of prostate cancer for each male enrolled in the plan who is:

1) at least 50 years of age and asymptomatic; or
2) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Child Wellness and Immunization:

100% coverage with no deductible for well baby and well child visits to age 2.

Eligibility for the TRICARE Supplement is limited to benefit eligible full-time employees and eligible family members who are under age 65 and enrolled in the Defense Enrollment Eligibility Reporting System (DEERS). This includes reservists who are ordered up to active duty for more than 30 days (coverage extended only while on active duty) or reservists receiving retirement pay at age 60 are eligible. Other restrictions apply. See ASI TRICARE Supplement Enrollment Guide for details.

The TRICARE Supplemental Medical Program is offered to TRICARE eligible employees. This option is designed to supplement TRICARE Standard and Extra; although coverage has been extended to those currently participating in TRICARE Prime. This fully insured Supplemental Medical plan is administered by Association & Society Insurance (ASI) Corporation and underwritten by The Hartford. This plan is designed to coordinate benefits with TRICARE, so between TRICARE and the TRICARE Supplement most eligible charges are reimbursed in full. In addition to no deductible or out of pocket expenses this medical plan option has a $0 premium across all coverage levels.

Benefits of Enrollment

- *Full reimbursement for TRICARE annual deductible ($150 individual / $300 Family)*
- *Full reimbursement of the 20% TRICARE Extra / 25% TRICARE Standard cost share*
- *Full reimbursement of Prescription Drug Co-pays*
- *Full reimbursement of applicable excess charges*
- *No pre-existing condition exclusion*
- *Between TRICARE and the TRICARE Supplement most eligible charges are reimbursed in full*

Some Restrictions Apply

- *The TRICARE Prime enrollment fee is not reimbursed by the Supplement.*
- *Eligibility for the TRICARE Supplement ends at age 65*
- *Provider access limited to TRICARE authorized civilian providers and military medical treatment facilities.*
- *Routine newborn and well baby care, dental care, treatment for drug and alcohol addiction, and prosthetic devices are limited to expenses covered by TRICARE.*

Filing Claims

You or your doctor should file your medical claims with TRICARE. Verify that your doctor will file your claim with ASI as a secondary payer. If your doctor will not, you must file your claim or submit your TRICARE Explanation of Benefits to ASI at the following fax number 301-816-1125.

Premiums paid entirely by COSA

DENTAL PLANS

The City of San Antonio recognizes that quality dental care is important to good health. We offer two dental programs for you to choose from; CitiDent DPO dental plan or DeltaCare Dental HMO.

Option 1 - CITIDENT - PPO

CitiDent is the City's PPO dental plan in which claims are processed and paid through the City's Medical Claims Administrator. This program allows participants to visit Preferred Dentists or the dentist of their choice. Once you have paid for eligible dental service, you simply submit your receipts to the claims administrator (Community First Health Plans) for reimbursement according to the schedule of benefits listed below.

Covered Dental Expenses

- Diagnostic and Preventive Treatment is paid at 100% of usual and customary charges without a deductible, such as: dental x-rays; dental exam; teeth cleaning (prophylaxis).
- Basic Dental Care is paid at 80% of usual and customary charges, after the deductible of $50 individual/$150 maximum family deductible, such as: fillings; stainless steel crowns; extractions and oral surgery; administration of anesthesia; and root canal therapy.
- Major Dental Care is paid at 50% of usual and customary charges, after the deductible, such as: inlays or crowns (other than stainless steel); full or partial dentures; periodontal prophylaxis; and gum surgery.
- Orthodontics or teeth straightening is paid at 50% of usual and customary charges after the deductible. This coverage is payable for covered dependents only who are at least 6 and not more than 19 years old when treatments begin.
-

CitiDent Plan - PPO

ANNUAL DEDUCTIBLE	$50 individual	$150 family
DENTAL EXPENSE BENEFITS		
Preventive/Diagnostic	100% of usual and customary no deductible	
Basic Services	80% of usual and customary after deductible	
Major Services	50% of usual and customary after deductible	
Orthodontics (Dependent children only)	50% of usual and customary after deductible	
MAXIMUM BENEFITS		
Annual per person	$1,200	
Annual per person (orthodontics)	$750	
Lifetime per person	$1,500	
LIMITS AND EXCLUSIONS	See Plan Document	

CITIDENT EMPLOYEE BI-WEEKLY COST

Employee Only	EE+1 Dependent	EE+2 or more Dependents
$14.00	$21.00	$31.50

DENTAL PLANS (cont'd)

Option 2 - Delta Dental DHMO

DeltaCare is a managed dental plan which is very much like an HMO, only for dental services.

DeltaCare includes many of the features that make a DHMO attractive to employees: no claim forms; no deductibles; no waiting periods for new participants; no pre-existing condition exclusion; no annual maximum; and worldwide emergency coverage is available. Similar to an HMO, DeltaCare members are required to select a network dentist who will ensure that the patient's dental care needs are met. If a dental specialist is required, then the referring primary care dentist will handle the referral. Benefits for specialty care are covered at the same guaranteed copayment as listed on the Schedule of Benefits and co-payments.

Contract dentist located in all areas of the City are available for employees to select. Different members of the employee's family may select different contract dentists. Dentist names and locations are listed in the DeltaCare information packet. As in HMO plans, contract dentists are subject to change. For verification of dentist, call the DeltaCare member services department at 1-800-422-4234 or visit their website at www.deltadentalins.com.

Under the DeltaCare DHMO Plan, employees are covered for most dental services. Employees are required to pay co-payments for dental services rendered by DeltaCare contract dentists. These co-payments vary depending on the type of service rendered at the time of treatment.

A partial list of services and co-payments is listed below:

DESCRIPTION……COPAYMENT

Each office visit (regardless of number or type of services rendered)……$5.00
Oral exam, x-rays, fluoride treatment……$0.00
Prophylaxis (teeth cleaning once every 6 months)*……$0.00
Periodontal scaling and root planning, per quadrant……$50.00
Fillings (amalgam or Resin) for one surface……$0.00
Surgical extraction, erupted tooth……$45.00
Root canal – molar……$210.00
Crown – porcelain fused to predominantly base metal**……$250.00
Orthodontics for children……$1800.00
Orthodontics for adults……$2,000.00

Please note that these are the applicable co-payments if work is performed by a Contract Dentist. For further information see the Schedule of Benefits and co-payment enclosed in your DeltaCare enrollment packet.

* Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by contract dentist.

**Molars additional

DELTA DENTAL EMPLOYEE BI-WEEKLY COST

Employee Only	EE+1 Dependent	EE+2 or more Dependents
$6.00	$9.50	$14.00

FLEXIBLE SPENDING ACCOUNTS (FSA)

Enjoy Greater Benefits! ***Take Home More Money!***

By Paying Lower Taxes!

WHAT IS A FLEXIBLE SPENDING ACCOUNT PLAN?

A Flexible Spending Account Plan (FSA) is an employee deferral plan that is authorized under various Sections of the Internal Revenue Code. An FSA plan can have several optional accounts and YOU can choose which, if any, you wish to participate in each year. It simply allows employees the opportunity to pay for certain healthcare and dependent day care expenses on a pre-tax basis.

You decide what optional accounts you wish to use and how much money (on an annual basis) to have deducted from your paychecks BEFORE taxes are calculated! When you elect to defer money into an account, that annual amount is divided by the number of paychecks in the year and a set amount is deducted each pay period. When you incur expenses under that account type, you file for reimbursement and receive the benefit tax free.

YOUR FSA ACCOUNT CHOICES INCLUDE:

- A Health Care Reimbursement Plan
- A Dependent Day Care Reimbursement Plan

A Range of Money Saving Options for you to Choose

Section 125 Healthcare FSA - You can set aside pre-tax money from your salary to pay for medical, dental, and vision expenses not covered by your healthcare plans, like copays and deductibles. These can be expenses for you and your eligible dependents.

Section 129 Dependent Day Care Account – You can elect to make contributions to this account for work related dependent day care expenses to allow you and your spouse to work or attend school full-time.

How Does an FSA Reimbursement Plan Work?

- First, YOU decide which of the accounts you wish to use for 2006 and the amount you expect to spend from those accounts during 2006.
- Next YOU complete the enrollment form and indicate the appropriate amounts for each account.
- Then, COSA will take the annual amount and divide it by the number of pay periods YOU have each year and that set amount will come out of each pay check.
- These dollars are taken out of your pay **BEFORE** taxes are taken out, and are contributed to your personal expense reimbursement accounts.

Sample Paycheck – Shows the Tax Savings Advantages

	With 125 Plan	***Without 125 Plan***
Gross Pay per Paycheck	$1,250.00	$1,250.00
Automatic Premium Account	-30.00	n/a
Health Care Account	-150.00	n/a
Dependent Day Care Account	-150.00	n/a
Taxable Income	$920.00	$1,250.00
Estimated Fed. Tax (15%)	-138.00	-187.50
FICA Tax (7.65%)	-70.38	-95.63
After Tax Expenses	n/a	-355.00
Take Home Pay per Paycheck	**$711.62**	**$611.87**
Annual Savings from FSA	**$1,197.00**	

How Does a Healthcare Reimbursement Plan Work?

- ***Note: For 2006, COSA will contribute $250 annually to a Healthcare FSA Account for each Employee who elects the CitiMed PPO plan. This is a one time option and may not be repeated in future years.***

- Once you have incurred an expense, at any time during the calendar year, you may access your account in several ways:

  1. If expenses are for a Medical copay or deductible (not paid through your FSA credit card), your out-of-pocket costs will be automatically sent by Community First to Alt Benefits (FSA Claims Administrator) and a check will be sent to YOU without you needing to request it.
  2. Use Your *"MySource"* FSA credit card to pay for the expense and save the receipts in case you are requested to submit them as required by the IRS rules.
  3. File a claim on the Reimbursement Request form provided to you on the COSA website and attach the necessary receipts.

- Reimbursements of Claims – Once a claim is received at Alt Benefits, we will review it and enter it for processing. We will cut checks weekly. We will cut a check for the entire amount of the eligible claim, up to the remaining balance of your annualized Health Care Reimbursement Plan salary reductions.

How Does a Dependent Care Expense Reimbursement Plan Work?

- You can submit proof of child-care expenses for qualifying individuals for reimbursement. Qualifying individuals include:
    1. Child under the age of 13 or 13 and over if the child is mentally or physically unable to care for himself/herself.
    2. Elderly dependents
    3. Disabled spouse
- The Dependent Care Reimbursement is similar to the Healthcare Reimbursement, except no advances can be taken. (We will reimburse you only up to the amount that has been deducted from your paycheck.)
- Once you have incurred an expense, at any time during the calendar year, you must file a claim on the Reimbursement Request form provided to you on the COSA website and attach the necessary receipts.
- Your claim submission must include the childcare provider's Tax ID Number.
- Employees in the 15.0% tax bracket usually are better off taking the child care credit off their tax return instead of participating in the Dependent Care Expense Reimbursement Plan.

HOW DO I FILE A CLAIM UNDER THE FSA PLANS?

When you incur an eligible expense, complete a Reimbursement Request Form and attach the receipt or explanation of benefits and e-mail with scanned attachments, fax or mail to:

Alt Benefit Consultants, Inc.
6410 Southwest Blvd., Suite 204
Fort Worth, TX 76109
Phone: (817)731-6258

Toll-Free Phone: (877)731-3532

Claims (9 pages or less) can be faxed to (817)731-9029!!

If the claim is for an expense applied to your deductible or co-pay from any insurance other then the CitiMed Plans ***(CitiMed deductibles and co-pays are automatically sent to Alt Benefits for reimbursement for you)*** please file with the insurance carrier first and then forward the Explanation of Benefits (EOB) along with the Reimbursement Request form to Alt Benefit Consultants for reimbursement.

WHAT ARE THE RULES?

Be sure to choose your annual elections carefully. Please remember you cannot change your benefit elections during the Plan Year, unless you have a qualified change in status, such as:

- Marriage or Divorce
- Birth or Adoption
- Death
- Employment status change for employee or spouse

(Please refer to the Summary Plan Description for details of qualified changes)

SPEND YOUR MONEY!!!

You will forfeit any unused money remaining at the end of the plan year.

Examples of Eligible Healthcare Reimbursement Plan Expenses

- Acupuncture
- Alcoholism/Drug Treatment
- Ambulance hire
- Artificial limbs
- Birth control pills
- Braille books and magazines
- Car controls for the handicap
- Chiropractors
- Co-insurance amounts you pay
- Contact lenses and cleaning solutions
- Cost of operations and related treatments
- Crutches
- Deductible health care coverage amounts
- Dental Fees
- Prescription Drug co-pays
- Eye glasses, including exam fee
- Hearing devices and batteries
- Hypnosis for treatment of an illness
- Insulin
- Laboratory fees
- Obstetrical expenses
- Orthopedic shoes
- Over the counter medicine (medically necessary)
- Physician fees
- Podiatry
- Psychiatric care
- Routine physicals
- Seeing – eye dog and its upkeep
- Telephone, special for deaf
- Television audio display equipment for the deaf
- Therapeutic care for drug and alcohol addiction

NOTE: Orthodontia & Maternity claims are reimbursed after services are rendered.

Items Not Covered include, but are not limited to:

- Cosmetic expenses including surgeries & procedures
- Nutritional supplements
- Weight-loss programs – unless medically necessary
- Fitness club memberships/dues

LIFE COVERAGE BENEFITS

The City of San Antonio provides basic life insurance with Aetna Life Insurance Company to help protect your family in the event of your death. In addition to the basic life insurance you receive, you are also eligible to buy additional supplemental life insurance for yourself.

Basic Term Life Coverage

All full-time employees are automatically covered under the Aetna's basic term life insurance plan. The City pays the entire cost of this coverage. If you die while covered under the basic life insurance plan, your beneficiary will receive a tax-free lump sum benefit equal to your annual base salary. You also have accidental death and dismemberment (AD&D) coverage which pays one time your annual salary to your beneficiary in the event of your accidental death.

Optional Additional Life Coverage

If you want additional life insurance coverage, the Benefits Program offers optional life insurance at various rates. In addition to the amount of life insurance the city provides, you may purchase supplemental life insurance in amounts equal to either:

- 1 time your annual base salary; 2 times your annual base salary; or 3 times your annual base salary

Evidence of insurability will be required for all new employees who elect supplemental coverage at 2x or 3x their annual salary or whose total coverage exceeds $200,000 and current employees who increase their coverage level to 3x annual salary or exceed $200,000 for the first time. Evidence of insurability forms can be obtained at the Employee Benefits Office or online at http://COSAWEB/benefits/forms. The review and determination of insurability will be handled by Aetna Life Insurance Company, the City's term life insurance underwriter.

The cost of coverage will vary based on your age and the coverage amount you choose. Employees who are over age 69 are also eligible for the city's basic and additional term insurance. Coverage amounts are based on age as shown on the following cost summary.

ADDITIONAL LIFE COVERAGE EMPLOYEE BIWEEKLY COST

	Employee Age	Cost Per $1,000
Cost per $1,000 of	Under 30	$.030
annual salary times	30-34	.044
amount of additional	35-39	.050
coverage desired equals	40-44	.068
biweekly premium	45-49	.119
	50-54	.184
	55-59	.319
	60-64	.530
	65-69	.808
	70-74	1.468
	Over 74*	1.843

* **NOTE**: Additional life insurance benefits (as well as the City-paid basic life policy) are reduced depending on age.

Age 70-74: 65% of annual salary
Age 75-79: 45% of annual salary
Age 80-84: 30% of annual salary
Age 85-89: 20% of annual salary
Age 90+: 10% of annual salary

LIFE COVERAGE BENEFITS (cont'd)

Your Right to Convert

Upon termination of employment with the city, you are no longer covered for any Basic or Additional Life Insurance policies. Your last day of employment is your last day of coverage.

> If you wish to continue this coverage, you have an option to convert the City's group policy to an individual policy. By converting, you will be responsible for the cost of this coverage. Aetna Life Insurance Company will notify you of the cost after you submit an application for conversion. If you are interested in converting to an individual life policy, please contact the Employee Benefits Office at 207-8705.

Choosing a Beneficiary

It is important to name a beneficiary. In the event of your death, benefits are paid by Aetna Life Insurance Company to your named beneficiary. A Beneficiary Designation Form is available in the Employee Benefits Office or on the COSAWEB for this purpose.

You should review your beneficiary form periodically to make sure that you have listed the person(s) or organization(s) whom you want to receive benefits in the event of your death. You may name more than one beneficiary and indicate the percentage of your death benefit each should receive. If minors are named, a guardian or trustee must be appointed on their behalf. You may wish to consult with an attorney to make sure that benefits to a minor will be paid according to your wishes. You may change your beneficiary designation at any time by completing a change of Beneficiary Form at the Employee Benefits Office.

Additional or Basic Life insurance coverage in excess of $50,000 is considered taxable income under IRS regulations. Below is the tax table for use in determining the tax per $1,000/month over $50,000. The payroll division will deduct this tax as a one time deduction on the last period of the year.

Tax Table

Annual bracket	Cost per $1,000 for one month
Under 25	$.05
25-29	.06
30-34	.08
35-39	.09
40-44	.10
45-49	.15
50-54	.23
55-59	.43
60-64	.66
65-69	$1.27

Benefits

VISION

BENEFITS AT A SPECTERA NETWORK PROVIDER	
COMPREHENSIVE VISION EXAM ($10 copay; Once every 12 months)	A vision examination is provided by a network optometrist or opthamologist, after applicable copay.
MATERIALS ($0 copay)	The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.
PAIR OF LENSES (for eyeglasses) (Once Every 12 Months) • Standard Single Vision • Standard lined bifocal • Standard lined trifocal • Standard lenticular	Standard scratch-resistant coating is covered-in-full. Poly carbonate lenses are covered-in-full Lens Options – Options such as progressive lenses, tints, UV, and anti-reflective coating may be available at a discount
FRAMES (Once Every 12 Months)	Spectera's frame benefit applies to vitrually all of the frames on the market today, and most of those are covered-in-full, without any additional cost to the member, other than applicable copay. Receive a $50 wholesale frame allowance (approximate retail value of $120 to $150) at private practice providers, or a minimum $130 frame allowance at retail chain providers.
CONTACT LENSES (in lieu of eyeglasses) (Once Every 12 Months)	
• Covered-in-full elective contact lenses	The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered-in-full (after applicable copay) for the most popular brands on the market. If covered disposable contact lenses are chosen, up to 6 boxes (depending on prescription) are included when obtained by a network provider. It is important to note that Spectera's covered-in-full contact lenses may vary by provider.
• All other elective contacts	A $150 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of Spectera's covered-in-full contacts (materials copay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.
• Necessary comtact lenses*	Covered-in-full (after applicable copay).
REFRACTIVE EYE SURGERY	Spectera participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit our website at www.spectera.com

BENEFITS AT AN OUT-OF-NETWORK PROVIDER		
SERVICE	AMOUNT	
Exam		If you choose an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to: Spectera Claims Department P.O. Box 26618 Baltimore, MD 21207-6618 Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.
Optometrist	up to $45	
Opthalmologist	up to $45	
Lenses		
Single Vision	up to $50	
Bifocal	up to $60	
Trifocal	up to $80	
Lenticular	up to $80	
Frames	up to $50	
Contact Lenses (in lieu of eyeglasses)		
Elective	up to $150	
Necessary*	up to $210	

*Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact Spectera concerning the reimbursement that Spectera will make before you purchase such contacts.

Spectera Employee Bi-Weekly Cost

Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$3.81	$6.81	$6.81	$10.09

EXTENDED SICK LEAVE

Short Term Disability

The City of San Antonio provides, at no cost to eligible city employees, a disability program. This program provides you with a percentage of your salary based on years of service for a maximum of 26 weeks if you are unable to work as a result of a non-work related disability.

Eligibility

- Any full-time civilian employee who suffers an off-the job injury or illness
- Has been off work for 5 consecutive working days and is under the care of a licensed physician
- Submits a complete application within 30 days of onset of disability for benefits under the program along with an attending physician's statement.

The purpose of the program is to provide regular full-time employees extended sick leave benefits for non-job-related illnesses or injuries. To be eligible for this program, an employee must have completed their six month probationary period and been on leave for illness/injury for five consecutive work days. The benefits are granted according to the following schedule:

NUMBER OF WEEKS OF BENEFITS
PERCENTAGE OF COMPENSATION

Years of Service	100%	80%	60%	50%	40%
6 months, but less than 1 year	0	0	6	7	13
1 year, but less than 5 years	0	4	9	13	Max. Duration
5 years, but less than 10 years	2	4	8	12	Max. Duration
10 years, but less than 15 years	4	9	13	0	Max. Duration
15 years or more	6	7	13	0	Max. Duration

Long Term Disability

The City of San Antonio also provides, at no cost to the employee, a long term disability program that pays a portion of your salary when you are unable to work as a result of a non-work related disability. Total benefits are calculated at 40% of salary minus all offsets (i.e. Social Security, other coverage, etc.)

Eligibility

- Any full-time civilian employee completing 26 weeks of short term disability; and
- Submits complete application filing for long term disability along with an attending physician statement.

Additional Long Term Disability (optional)

To supplement your long term disability coverage, the City offers employees the option to purchase additional long term disability coverage. If you purchase supplemental coverage you will be eligible to receive an additional 20% of your salary in long term disability protection. Total benefits with the purchase of additional long term disability are calculated at 60% of salary minus offsets (i.e. Social Security, other coverage, etc.)

Features

- Total benefits paid with the purchase of supplemental coverage increase to 60% of salary minus all offsets (i.e. Social Security, other coverage, etc.)
- All disability payments are considered taxable income and subject to withholding.

EMPLOYEE BI-WEEKLY COST

Long Term Disability	Monthly Salary X.0021 = Biweekly Premium

Note: This program will not benefit newly hired employees during their first year of employment.

RETIREMENT BENEFITS

Texas Municipal Retirement System (TMRS)

The City of San Antonio offers a mandatory retirement plan to its full-time non-uniformed employees upon their date of hire with the city. This retirement plan is administered by Texas Municipal Retirement System (TMRS). Contact TMRS at (800) 924-8677 or on the web at www.tmrs.org

- The employee contribution to the plan is 6% of salary.
- City's contribution is 2 times employee contribution.
- Employees become 100% vested after 5 years of service.
- Criteria for retirement: 5 years of service at age 60, or 20 years of service at any age.

Deferred Compensation

The City of San Antonio offers two voluntary Section 457 Deferred Compensation Plans to all full-time civilian employees. Deferred compensation is a supplemental retirement savings program which allows an employee to contribute a portion of salary before federal taxes.

- The minimum contribution for deferred compensation is $10 per pay period.
- The maximum contribution for 2006 is $ 15,000 (Employees over 50 may elect an additional $5,000) .
- There are 26 payroll deductions for deferred compensation per calendar year.

This voluntary program is offered by Nationwide (PEBSCO) 1-877-677-3678; and ICMA Retirement Corporation, 1-800-735-7202. Forms may be obtained from these companies in the Employee Benefits office.

SUMMARY OF HEALTHCARE BENEFITS AND RATES

This is a brief summary of benefits. Please refer to the CitiMed Plan Summary Document and HMO plan documents for additional coverage, limitations and exclusions.

Benefits

Plan Benefit CitiMed	In Network Benefits PPO	Out of Network Benefits PPO	HMO
Maximum Benefits			
Lifetime Maximum Benefit	$1,000,000	$1,000,000	None
Deductibles and Out-of-Pocket Maximums			
Annual Deductible	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family	None
Annual Out of Pocket Maximum (does not include the annual Deductible)	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$1,000 Individual $2,500 Family *excludes pharmacy copays
Inpatient Hospital and outpatient surgery	80% after deductible for semi-private room Pre-certification required	60% after deductible up to $200/day Pre-certification required	100%
Office Visits	$15 copayment	60% after deductible	$15 copayment
Ambulance	80% after deductible	60% after deductible	$100%
Physicians Services (other than office visit)	80% after deductible	60% after deductible	100%
Allergy Testing	80% after deductible	60% after deductible	$15 copayment
Allergy Injections	80% after deductible	60% after deductible	$15 copayment
Ambulatory Surgical Center	80% after deductible	60% after deductible	$15 copayment
Durable Medical Equipment	80% after deductible	60% after deductible	100% to a max of $2,000/yr
External Prosthetic Appliances	80% after deductible	60% after deductible	100%
TMJ	80% after deductible	60% after deductible	100%
Skilled Nursing Facility	80% after deductible	60% after deductible	$15 copay limit 120 days/yr
X-Ray and Lab	80% after deductible	60% after deductible	100%
Hospice Care Provider Services	80% after deductible	60% after deductible	100%
Occupational, Speech, and Physical Therapy	80% after deductible to a max of $1,000/yr	60% after deductible to a max a $1,000/yr	$15 copay up to $500/yr
Mental Health Benefits			
Inpatient serious mental illness	45 days at 80% after deductible	45 days at 60% after deductible	100% up to 30 days/yr
Physician Services – office visits	$15.00 co-pay Limit 60 visits/yr	60 visits at 60% after deductible	$25 copay Limit 20 visits/yr
Inpatient (non-serious mental illnesses.	30 days at 80% after deductible	30 days at 60% after deductible	100% up to 30 days/yr
Physician Services-office or day treatment	60 days at 80% after deductible	60 days at 60% after deductible	$25 copay Limit 20 visits/yr
Substance Abuse/Alcoholism	80% after deductible	60% after deductible	100% inpatient $15 copay outpatient

Benefits

Pregnancy and Newborn Benefits			
Prenatal Care	80% after deductible	60% after deductible	$15 copay initial visit
Delivery	80% after deductible	60% after deductible	100%
Newborn Child	100% for first 3 days and then 80% after deductible	60% after deductible	100%
Preventative Health Care Benefits			
Dependent Children – well visits **Age 2 and above**	100% Birth to age 2 no annual dollar limit 100% up to $300/yr	60% after deductible up to Maximum $300 per calendar year	$15 copay
Routine Physical Exams – 1 / yr	100% up to Maximum $300 per calendar year	60% after deductible up to Maximum $300 per calendar year	$15 copay
Immunizations for dependent children	100%	60% after deductible	$15 copay
Pap Test – 1 / yr	100%	60% after deductible	$15 copay
Mammogram – 1/yr	100% for women age 35 and older	60% after deductible for women age 35 and older	100%
PSA Test – 1 / yr	100% for men age 50, or age 40 with family history, and older	60% after deductible for men age 50 and older, or 40 and older with family history	100%
Supplemental Accident Benefits			
Hospital and Medical Expenses resulting from an Accidental Injury	100% up to Maximum of $500 per person, for charges incurred within 90 days of date of the accident	100% up to Maximum of $500 per person, for charges incurred within 90 days of the date of the accident	$15 copay or $100 copay for Emergency Room
Prescription Drugs			
30-day supply **Generic** **Preferred Brand** **Brand** **90-day Retail (Walgreen's only)** **Generic** **Preferred Brand** **Brand** **90-day Mail Order** **Generic** **Preferred Brand** **Brand**	 $7 Copay $20 Copay $40 Copay $21 Copay $60 Copay $120 Copay $0 Copay $30 Copay $30 Copay	 50% after Deductible 50% after Deductible 50% after Deductible	 $10 Copay $20 Copay $40 Copay $20 Copay $40 Copay $80 Copay Not Available Excludes Oral Contraceptives

2006 RATE SUMMARY

Cost for Coverages

The following are rates for the City of San Antonio Flexible Benefits Program. These rates are effective January 1, 2006, and will be deducted beginning with the paycheck issued on January 13, 2006. Use the Benefits Worksheet found in the back of your Enrollment Guide to calculate your bi-weekly premium

FLEX BENEFIT PLAN OPTIONS	**Employee Only**	**Employee +Child(ren)**	**Employee + Spouse**	**Employee + 2 or more**
Medical	Bi-Weekly Premium	Bi-Weekly Premium	Bi-Weekly Premium	Bi-Weekly Premium
CitiMed PPO Plan	$3.50	$12.50	$21.00	$29.50
CitiMed HMO Plan	$24.00	$50.00	$61.50	$85.00
TRICARE Supplement	$0	$0	$0	$0
	Employee Only	**Employee +Child (1 only)**	**Employee + Spouse**	**Employee + 2 or more**
Dental	Bi-Weekly Premium	Bi-Weekly Premium	Bi-Weekly Premium	Bi-Weekly Premium
CitiDent	$14.00	$21.00	$21.00	$31.50
DeltaCare DHMO	$6.00	$9.50	$9.50	$14.00
Vision Plan	Bi-Weekly Premium	Bi-Weekly Premium	Bi-Weekly Premium	Bi-Weekly Premium
Spectara	$3.81	$6.81	$6.81	$10.09
Life Insurance	**Employee Age**	**Premium Multiplier**	**Current Salary / $1,000**	**Bi-weekly Premium**
Cost per $1,000 of annual salary times amount of additional coverage desired equals biweekly premium	Under 30	$.030		
	30-34	.044		
	35-39	.050		
	40-44	.068		
	45-49	.119		
	50-54	.184		
	55-59	.319		
	60-64	.530		
	65-69	.808		
	70-74	1.468		
	Over 74	1.843		

LONG TERM DISABILITY: monthly salary x.0021 = biweekly salary

HEALTH CARE REIMBURSMENT: up to $208.30 biweekly

DEPENDENT CARE REIMBURSEMENT: up to $208.30 biweekly

Enrollment

Completing The Enrollment Form

Name, Address, & Phone Numbers

Review the information in the left column and make any changes with your payroll officer.

Section 1 - Employee Data

If you receive a pre-printed form Section 1 shows your 2005 benefit choices with the 2006 rates for the same coverage. Review this information to decide if you want to keep the same coverage or make changes for 2006.

Section 2 - Dependent Data

This section shows the dependents currently covered under your plan. If you need to make any changes indicate them in section 4 & 5.

Section 3 - Contract Agreement & Payroll Authorization

Your benefit choices cannot become effective if your form is not signed and dated. By signing the form, you are indicating that you understand the choices you have made, and you are instructing the City to enroll you in the plans you have chosen and begin subtracting from your pay the amounts you have authorized. Return your completed form to your department payroll clerk.

Section 4 Coverage Changes for 2006

To make your selections, complete categories I through VIII. If you choose an HMO or DHMO plan, make sure you enclose a completed enrollment form and have selected a primary care provider.

I. Martial Status: Mark one box only to indicate your current marital status.

II. Coverage Level: Mark the applicable level of coverage for your dental, medical or vision coverage (only one level of coverage may be chosen)

III. Medical Coverage: Mark only one box to indicate your choice of CitiMed PPO Health Plan, or Community First (Note: If you choose Community First HMO you must complete an CFHP Enrollment form), or if you choose to waive medical coverage, mark the box labeled "none". A signed "Waiver of Coverage" form must be completed to elect this option.

IV. Dental Coverage: Mark one box to indicate your choice of coverage.

V. Vision Coverage: Mark one box to indicate your choice of coverage.

VI. Additional Life Insurance: Mark one box to indicate your choice of 1, 2, or 3 times additional *supplemental life insurance. NOTE: If additional life is selected, complete additional Term Life Insurance Application. Employees electing term life insurance for the first time or in an amount of 3x annual salary or in excess of $200,000 will have to complete an evidence of insurability as a condition of enrollment and will not be able to complete their enrollment online.*

VII. Additional Long Term Disability: Mark one box to indicate your choice of coverage.

Enrollment (cont'd)

VIII. Reimbursement Accounts: Mark the first box only if you do not want either reimbursement account. If you mark either health Care or Dependent Care boxes you must also indicate the amounts you wish to deduct **bi-weekly** for either or both of these sections. (limited to $208.30 bi-weekly).

Section 5 - If you choose an HMO

- You must choose a primary care physician from the list provided by the HMO. Doctors outside the HMO cannot be chosen.
- Referrals to specialists must be accomplished through the guidelines of your HMO.
- If the doctor or doctors you choose terminate their contract with the HMO during the benefit year, you must choose another doctor within the HMO. This is not a family status change and no change in your coverage option is allowed.

Section 6 - Dependent Changes for 2006

Complete this section if any dependents need to be added or dropped from your plan.

1. List each dependent by name, date of birth, relation code and social security number, and add drop category. If you select or are switching to an HMO, please enclose the HMO Enrollment form.
2. Continuing coverage in 2006 for a dependent who was covered in 2005 requires no change*. (Dependent's social security number must be listed).*
3. If your spouse is employed, complete this section with name and telephone number of employer.

What Happens If You Don't Enroll?

If you do not submit an enrollment form you will automatically be enrolled in the benefit selection you made for 2005**.**

Once enrolled, no changes will be allowed. You automatically forfeit the right to make new selections from the following benefits for the entire plan year *January 1-December 31.*

- ☐ Medical Coverage Choices
- ☐ Dental Coverage
- ☐ Vision Coverage
- ☐ Additional Supplemental Life Insurance
- ☐ Additional Long Term Disability
- ☐ Health Care Reimbursement
- ☐ Dependent Care Reimbursement

Enrollment (cont'd)

Changes to the Plan

Although the City does not anticipate any changes, the provisions of the summary plan descriptions permit these plans to be amended at any time. *You will be notified if a change occurs that will affect your benefits.*

Last But Not Least

The material in this booklet highlights the *main features* of the City's *Employee Benefits Program,* which is based on *legal plan documents, insurance contracts, and current tax laws.* ***Should any questions arise regarding the nature and extent of your benefits, the formal health plan document and contracts on file will supersede this booklet.***

BENEFITS WORKSHEET

Use this worksheet along with the rates section of your program to determine the bi-weekly cost of your selected benefits.

A. SELECT YOUR COVERAGE STATUS BELOW (check one):

- ☐ Employee Only
- ☐ Employee and Child(ren)
- ☐ Employee and Spouse
- ☐ Employee and Family

NOTE: This will be the coverage level you use to determine the costs for the medical, dental, and vision plan(s) you select. Dental and vision plans are optional. **YOU MUST USE THE SAME COVERAGE LEVEL FOR ALL PLANS YOU SELECT.**

B. MEDICAL PLANS (One medical plan MUST be selected) ☐ CitiMed Health Plan, PPO ☐ Community First, HMO	**$**
C. DENTAL PLANS (optional) ☐ CitiDent, PPO ☐ Protective Dental, DMO	**$**
D. VISION PLAN (optional)	**$**
E. ADDITIONAL LIFE INSURANCE (optional)	

	(a)	(b)	(c)	(d)	(e)	
	$_____	**X _____**	**=_____**	**X_____**	**=_____**	**$**
	Employee Annual Salary/$1000	Level of coverage 1,2, or 3	Amount of Additional Coverage	Bi-weekly Premium Multiplier	Total Premium	

F. ADDITIONAL LONG TERM DISABILITY (Monthly annual salary x $ .0021)	**$**
G. HEALTH CARE REIMBURSEMENT ACCOUNT (Limit of $208.30 bi-weekly)	**$**
H. DEPENDENT CARE REIMBURSEMENT ACCOUNT (Limit of $208.30 bi-weekly)	**$**
I. TOTAL BIWEEKLY COST (Add bi-weekly premiums B through H and enter here)	**$**

After you have calculated your options, complete the enrollment form enclosed in your benefits packet.

FLEXIBLE SPENDING ACCOUNT WORKSHEET

Healthcare Account

Estimate your uninsured medical costs per **YEAR**. This should include your best estimate of **all family medical costs, including:**

- Eye Care (glasses, contact lenses, exams) $_____
- Over the Counter Drugs $_____
- All prescription co-pays $_____
- Health Insurance deductibles $_____
- Co-insurance and/or co-pay amounts $_____
- Dental expenses not covered by insurance $_____

Total Yearly Uninsured Healthcare Expenses $_____

Note: In an FSA plan, you do not have to meet the 7.5% adjusted gross income threshold that is required on a Schedule A of the 1040 tax return. Therefore, your first dollar of uninsured healthcare costs can be paid with tax-free dollars.

Dependent Day Care Account

Estimate your dependent day care costs per year. This should include your best estimate of all dependent day care costs including:

- Pre-school and day care center costs for children under age 13, or dependent parents $_____
- After school and Summer day care costs $_____

Total Yearly Dependent Day Care Expenses $_____

Remember all expenses are only eligible if they are necessary to allow you and your spouse to work.